

Case Number:	CM14-0095981		
Date Assigned:	09/22/2014	Date of Injury:	09/11/2007
Decision Date:	01/14/2015	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	06/24/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Family Physician, and is licensed to practice in New York. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The members DOI is reported as 11 Sep 07. The mechanism of the injury is not discussed. The member is reported to have undergone laminectomies at L4-5 and L5-S1 with apparent failure to relieve her LBP and L radicular symptoms. She has had a variety of procedures since to include a Radio Frequency Ablation on the L in April 2013 that appeared to provide relief of her radicular symptoms for approximately the better part of a year. The most recently reported MRI from 27Jul13 showed moderate canal stenosis at L3-4, moderate canal Stenosis at L4-5 and moderate bilateral neural foraminal narrowing with the bulging disk contacting the L4 nerve roots bilaterally. Average pain was reported as 4/10 at a visit 18Dec13 whereas at the 9Apr14 appointment it was now listed at 7/10 with a recurrence of LLE radicular symptoms. She underwent a Transforaminal Epidural Steroid injection at that appointment. The patient was reported to continue to work as a pharmacy technician spending a large amount of time on her feet. The patients medications were listed as Fentanyl 50mcg q 3 days, Celebrex 200mg bid, Lyrica 75mg bid, Norco 10/325mg up to qid prn, Soma (carisoprodol) 350mg bid, Prilosec 20mg qd and Phentermine 37.5mg bid (weight loss medication covering her BMI of 32). The listed diagnoses include: Chronic LBP with L leg radiculopathy, S/P Laminectomy/Decompression L4-5, L5-S1, Myofascial Pain/Spasm. The issues under consideration are NON-CERTIFICATION of Celebrex and Carisoprodol (Soma).

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Celebrex 200mg day supply: 30 QTY : 60 refills: 00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11, 22, 68.

Decision rationale: According to the MTUS Anti-inflammatories and Acetaminophen is the traditional first line of treatments for LBP to reduce pain so activity and functional restoration can resume. In patients with moderate to severe disease, initial treatment with an NSAID may be warranted. For the management of hip, knee and hand Osteoarthritis a Cochrane review suggested that non-steroidal anti-inflammatory drugs (NSAIDs) are more efficacious for osteoarthritis than acetaminophen in terms of pain reduction, global assessments and improvement of functional status. For management of chronic LBP NSAIDs have been shown to have more adverse effects than placebo and acetaminophen but fewer adverse effects than muscle relaxants and narcotic analgesics. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concluded that available evidence supports the effectiveness of non-steroidal anti-inflammatory drugs (NSAIDs) in chronic LBP. Additionally after there has been evidence of failure of first-line medication options such as NSAID's and considering the use of opioids in the face of moderate to severe pain, opioids are recommended to be used in conjunction with the NSAID's rather than as a replacement. The member has returned to work and there are no reported GI side effects or intolerance to the Celebrex. The member remains on long term Opioids (Fentanyl and Hydrocodone/APAP). The member had done well in the past since execution of a RFA but is now experiencing a resurgence of L side radicular symptoms and underwent a Transforaminal Epidural Steroid injection at this visit likely to induce a temporary flare of pain from the procedure. I disagree that the chronic use of Celebrex in this case of long standing LBP and Failed Lumbar Laminectomy Syndrome is not warranted. The current dosing which significantly exceeds the maximum recommended dose presents a risk for increased cardiovascular events, therefore the request is not medically necessary.

Carisoprodol 350mg day supply: 30 QTY: 60 refills: 00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29, 63.

Decision rationale: Per the MTUS, if choosing to use muscle relaxants then a non-sedating muscle relaxants can be used with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. In most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Carisoprodol unfortunately has significant issues associated with both its primary action with centrally driven sedative effects and its

primary metabolite (Meprobamate - a Schedule IV drug). Carisoprodol has a high potential for abuse particularly when used in combination with hydrocodone to produce a heroin like effect and to help deal with the downside of cocaine abuse (coming down). I see documentation repeated in regard to the treatment agreement on the appropriate use of medications but I cannot find an UDS drug screen reports. The member is reported to have responded to the medications and to not have any apparent side effects and the member is reported to be working. However in the body of the notes there is mention of myofascial pain syndrome and failed post-laminectomy syndrome but I do not see evidence for recurrent or persistent muscle spasm either reported by the member or found on the limited information supplied in regard to examination of the patient. The MTUS Chronic Pain management guide clearly does not recommend Carisoprodol for chronic use in the management of LBP. The request is not medically necessary.